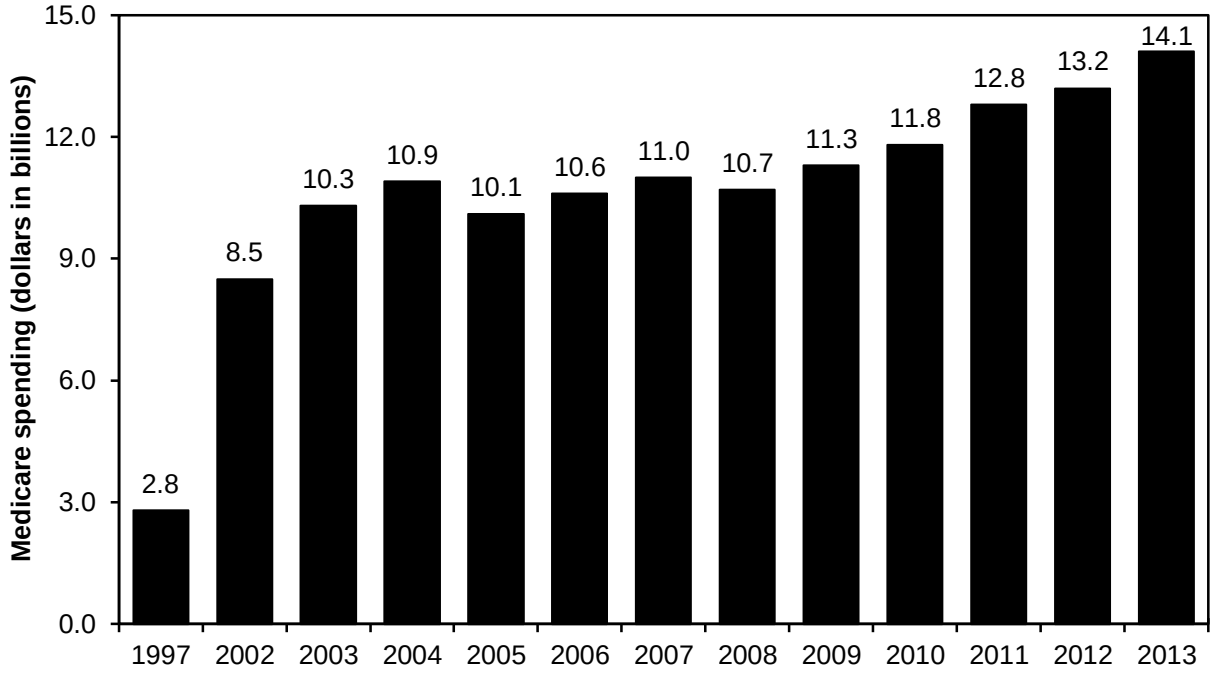
SECTION 10

Prescription drugs

Chart 10-1. Medicare spending for Part B drugs furnished in physicians' offices or by suppliers



Note: Data include Part B–covered drugs administered in physicians' offices or furnished by suppliers (e.g., certain oral drugs and drugs used with durable medical equipment). Data do not include Part B–covered drugs furnished in hospital outpatient departments or dialysis facilities. "Medicare spending" includes program payments and beneficiary cost sharing. Data for 2013 include the effect of the sequester, which reduced Medicare program payments by 2 percent beginning April 1, 2013. Data reflect all Part B drugs regardless of whether they are paid based on the average sales price plus 6 percent or another payment formula.

Source: MedPAC analysis of Medicare claims data.

- Medicare spending for Part B drugs furnished in physicians' offices or by suppliers totaled about $14.1 billion in 2013, an increase of about 6.5 percent from the 2012 level.

- Medicare spending on Part B drugs furnished in physician offices or by suppliers increased at an average rate of 25 percent per year from 1997 to 2003. In 2005, the Medicare payment rate changed from one based on the average wholesale price to 106 percent of the average sales price. With the move to the new payment system, spending declined 8 percent in 2005. Since 2005, spending has increased at an average annual rate of just over 4 percent.

- Reduced use of darbepoetin alfa and epoetin alfa (annual spending has declined by more than $1.3 billion since 2005) has contributed to slower growth in physician and supplier Part B drug spending.

- Total spending displayed in the chart does not include drugs provided through hospital outpatient departments (HOPDs). Separately paid HOPD drugs have grown rapidly in recent years—from about $3.5 billion in 2009 to about $6.7 billion in 2013.

Chart 10-2. Top 10 Part B drugs furnished in physicians' offices, by suppliers, and in hospital outpatient departments (in millions), 2012 and 2013

	Total Part B drug spending		Physician and supplier Part B drug spending		Hospital outpatient Part B drug spending	
Part B drug	2012	2013	2012	2013	2012	2013
Rituximab	$1,429	$1,528	$876	$880	$553	$648
Ranibizumab	1,278	1,376	1,220	1,325	57	51
Infliximab	1,002	1,127	704	757	297	370
Pegfilgrastim	1,063	1,113	643	629	420	484
Aflibercept	27*	1,094	N/A	1,028	27	66
Bevacizumab	1,022	1,050	625	606	397	444
Immune globulin	880	960	407	431	473	529
Denosumab	493	640	347	429	146	211
Pemetrexed	517	555	292	296	225	259
Trastuzumab	468	509	273	270	196	239
Total spending, top 10 Part B drugs	**8,179**	**9,952**	**5,387**	**6,652**	**2,792**	**3,300**
Total spending, all Part B drugs	**19,230**	**20,737**	**13,191**	**14,054**	**6,039**	**6,683**

Note: N/A (not available). The 10 Part B drugs with the highest total Medicare expenditures in 2013 are displayed in the table. Data for hospital outpatient departments include only separately paid drugs. Data do not include Part B drugs furnished in dialysis facilities. Medicare spending includes Medicare program payments and beneficiary cost sharing. Data for 2013 include the effect of the sequester, which reduced Medicare program payments by 2 percent beginning April 1, 2013. Data may not sum to total due to rounding. Data reflect all Part B drugs regardless of whether they are paid based on the average sales price plus 6 percent or another payment formula.
*Data for aflibercept are not available for the physician office setting in 2012 because the product was billed under a "not-otherwise-classified" billing code.

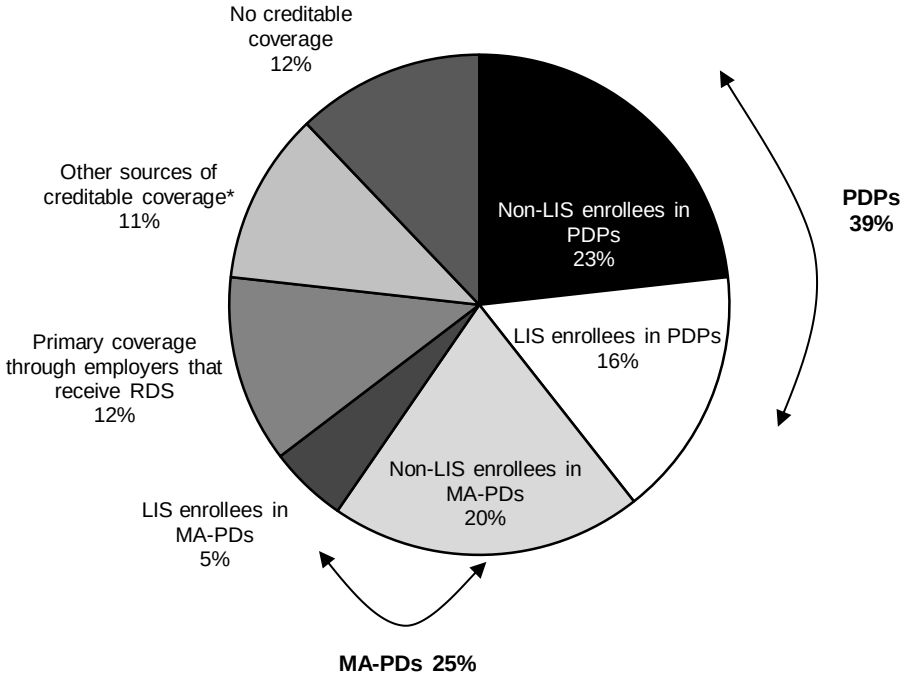
Source: MedPAC analysis of Medicare claims data from CMS.

- Medicare covers roughly 600 outpatient drugs under Part B, but spending is very concentrated. Medicare spending (including cost sharing) on the top 10 drugs, 9 of which were biologics, totaled nearly $10 billion in 2013, about 48 percent of all Part B drug spending that year.

- Total spending on Part B drugs increased by about 7.8 percent from 2012 to 2013. During this period, Medicare spending on Part B drugs grew by about 10.7 percent in hospital outpatient departments and by 6.5 percent for Part B drugs furnished by physicians or suppliers.

- Many of the top 10 drugs are used to treat cancer or its side effects (rituximab, pegfilgrastim, bevacizumab, pemetrexed, denosumab, trastuzumab). Drugs used to treat age-related macular degeneration (ranibizumab, aflibercept, and bevacizumab), rheumatoid arthritis (rituximab and infliximab), and immune disorders (immune globulin) are also included in the top 10.

Chart 10-3. In 2012, almost 90 percent of Medicare beneficiaries were enrolled in Part D plans or had other sources of creditable drug coverage



Note: LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), RDS (retiree drug subsidy). Percentages may not sum to 100 due to rounding.
* "Creditable coverage" means the value of drug benefits is equal to or greater than that of the basic Part D benefit.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey Access to Care file 2012.

- Over three-quarters of Medicare beneficiaries were either signed up for Part D plans or had prescription drug coverage through employer-sponsored plans under Medicare's RDS in 2012. (If an employer agrees to provide primary drug coverage to its retirees with a benefit value that is equal to or greater than that of Part D (called "creditable coverage"), Medicare provides the employer with a tax-free subsidy for 28 percent of each eligible individual's drug costs that fall within a specified range of spending.)

- About 21 percent of Medicare beneficiaries received Part D's LIS in 2012. Among all LIS beneficiaries, about three-quarters (16 percent of all Medicare beneficiaries) were enrolled in stand-alone PDPs and the remainder (5 percent of all Medicare beneficiaries) were in MA–PD plans.

- Other enrollees in stand-alone PDPs accounted for 23 percent of all Medicare beneficiaries. Another 20 percent were in MA–PD plans or other private Medicare health plans. Individuals whose employers received Medicare's RDS accounted for 12 percent.

(Chart continued next page)

Chart 10-3. In 2012, almost 90 percent of Medicare beneficiaries were enrolled in Part D plans or had other sources of creditable drug coverage (continued)

- Other Medicare beneficiaries had creditable drug coverage, but that coverage did not affect Medicare program spending. Examples of other sources of creditable coverage include the Federal Employees Health Benefits program, TRICARE, Department of Veterans Affairs, and employers not receiving the RDS.

- About 12 percent of Medicare beneficiaries had no drug coverage or coverage that was less generous than Part D's defined standard benefit.

Chart 10-4. Changes in parameters of the Part D defined standard benefit over time

	2006	2013	2014	2015	Cumulative change 2006–2015
Deductible	$250.00	$325.00	$310.00	$320.00	28%
Initial coverage limit	2,250.00	2,970.00	2,850.00	2,960.00	32%
Annual out-of-pocket threshold	3,600.00	4,750.00	4,550.00	4,700.00	31%
Total covered drug spending at annual out-of-pocket threshold	5,100.00	6,954.52	6,690.77	7,061.76	38%
Minimum cost sharing above the annual out-of-pocket threshold					
Copay for generic/preferred multisource drugs	2.00	2.65	2.55	2.65	33%
Copay for other prescription drugs	5.00	6.60	6.35	6.60	32%

Note: Under Part D's defined standard benefit, the enrollee pays the deductible and then 25 percent of covered drug spending (75 percent paid by the plan) until total covered drug spending reaches the initial coverage limit (ICL). Before 2011, enrollees exceeding the ICL were responsible for 100 percent of covered drug spending up to the annual out-of-pocket threshold. Beginning in 2011, enrollees face reduced cost sharing in the coverage gap. For 2011 and later years, the amount of total covered drug spending at the annual out-of-pocket threshold depends on the mix of brand and generic drugs filled during the coverage gap. The amounts shown are for individuals not receiving Part D's low-income subsidy who have no other source of supplemental coverage. Cost sharing paid by most sources of supplemental coverage does not count toward this threshold. The enrollee pays nominal cost sharing above the limit.

Source: CMS, Office of the Actuary.

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 specified a defined standard benefit structure. In 2015, it has a $320 deductible, 25 percent coinsurance on covered drugs until the enrollee reaches $2,960 in total covered drug spending, and then a coverage gap until out-of-pocket spending reaches the annual threshold. Before 2011, enrollees were responsible for paying the full discounted price of covered drugs filled during the coverage gap. Because of changes made by the Patient Protection and Affordable Care Act of 2010, enrollees face reduced cost sharing for drugs filled in the coverage gap. In 2015, the cost sharing for drugs filled during the gap phase is 45 percent for brand-name drugs and 65 percent for generic drugs. Enrollees with drug spending that exceeds the annual threshold pay the greater of $2.65 to $6.60 per prescription or 5 percent coinsurance.

- The parameters of this defined standard benefit structure have changed over time at the same rate as the annual change in average total drug expenses of Medicare beneficiaries. The benefit parameters have generally increased over time, with the exception of 2014. (The reduction in 2014 reflects a decrease in average drug expenses CMS estimated for the period between August 2012 and July 2013.) The parameters have grown cumulatively by 28 percent to 38 percent between 2006, the year Part D began, and 2015. (Although the benefit parameters are all indexed to the same factor—the annual change in average total drug expenses—the actual changes differ across the parameters because of different rounding rules that are applied. In the case of total covered drug spending at the annual out-of-pocket threshold, the growth rate calculated is also affected by the mix of brand and generic drugs filled during the coverage gap.)

(Chart continued next page)

Chart 10-4. Changes in parameters of the Part D defined standard benefit over time (continued)

- Within certain limits, sponsoring organizations may offer Part D plans that have the same actuarial value as the defined standard benefit but a different benefit structure, and most sponsoring organizations do offer such plans. For example, a plan may use tiered copayments rather than 25 percent coinsurance or have no deductible but use cost-sharing requirements that are equivalent to a rate higher than 25 percent. Both defined standard benefit plans and plans that are actuarially equivalent to the defined standard benefit are known as “basic benefits.”

- Once a sponsoring organization offers one plan with basic benefits within a prescription drug plan region, it may also offer a plan with enhanced benefits—basic and supplemental coverage combined.

Chart 10-5. Characteristics of Medicare PDPs

	2014				2015			
	Plans		Enrollees as of February 2014		Plans		Enrollees as of February 2015	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	1,169	100%	18.6	100%	1,001	100%	19.2	100%
Type of organization								
National[a]	725	62	16.0	86	707	71	16.4	86
Other	444	38	2.5	14	294	29	2.8	14
Type of benefit								
Defined standard	36	3	0.4	2	0	0	0.0	0
Actuarially equivalent[b]	549	47	10.2	55	454	45	10.6	55
Enhanced	584	50	7.9	43	547	55	8.6	45
Type of deductible								
Zero	553	47	8.0	43	420	42	9.3	49
Reduced	42	4	0.7	4	139	14	1.4	7
Defined standard[c]	574	49	9.8	53	442	44	8.5	44
Drugs covered in the gap								
Some coverage	244	21	2.2	12	261	26	2.0	10
None	925	79	16.4	88	740	74	17.2	90

Note: PDP (prescription drug plan). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. Figures may not sum to totals due to rounding.
[a] Reflects total number of plans for organizations with at least 1 PDP in each of the 34 PDP regions.
[b] Includes "actuarially equivalent standard" and "basic alternative" benefits.
[c] $310 in 2014 and $320 in 2015.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

- Between 2014 and 2015, the number of stand-alone PDPs decreased by 14 percent. Plan sponsors are offering 1,001 PDPs in 2015 compared with 1,169 in 2014.
- In 2015, 71 percent of all PDPs are offered by sponsoring organizations that have at least 1 PDP in each of the 34 PDP regions. Plans offered by those national sponsors account for 86 percent of all PDP enrollment.
- For 2015, a larger share of PDP offerings include enhanced benefits (basic plus supplemental coverage) than in 2014. The share of PDPs with actuarially equivalent benefits (having the same average value as the defined standard benefit but with alternative benefit designs) declined slightly and sponsors are offering no PDPs with the defined standard benefit in 2015. Although actuarially equivalent plans continue to attract the largest share of PDP enrollees (55 percent), the share of enrollees choosing to enroll in enhanced benefit plans increased slightly from 43 percent to 45 percent between 2014 and 2015.
- Although a larger share of PDPs includes gap coverage for generic drugs in 2015 than in 2014, the majority of PDP enrollees (90 percent) continue to enroll in plans that offer no additional benefits in the coverage gap. However, because of the changes made by the Patient Protection and Affordable Care Act of 2010, the Part D benefit now includes some coverage for medications filled during the gap phase. In addition, many PDP enrollees receive Part D's low-income subsidy, which effectively eliminates the coverage gap.

Chart 10-6. Characteristics of MA–PDs

	2014				2015			
	Plans		Enrollees as of February 2014		Plans		Enrollees as of February 2015	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Totals	1,615	100%	9.9	100%	1,608	100%	10.6	100%
Type of organization								
Local HMO	1,066	66	7.0	71	1,123	70	7.6	72
Local PPO	436	27	1.8	18	409	25	1.9	18
PFFS	83	5	0.2	2	50	3	0.2	2
Regional PPO	30	2	0.9	9	26	2	0.9	8
Type of benefit								
Defined standard	40	2	0.1	1	39	2	0.1	1
Actuarially equivalent*	153	9	1.0	10	268	17	2.9	27
Enhanced	1,422	88	8.8	89	1,301	81	7.6	72
Type of deductible								
Zero	1,326	82	8.5	86	1,014	63	6.0	57
Reduced	188	12	1.1	11	337	21	3.4	32
Defined standard**	101	5	0.3	3	257	16	1.2	11
Drugs covered in the gap								
Some coverage	809	50	5.1	51	703	44	4.8	45
None	806	50	4.8	49	905	56	5.8	55

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). The MA–PD plans and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B–only plans. Numbers may not sum to totals due to rounding.
* Includes "actuarially equivalent standard" and "basic alternative" benefits.
** $310 in 2014 and $320 in 2015.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

- There are slightly fewer MA–PD plans in 2015 than in 2014. Sponsors are offering 1,608 MA–PD plans compared with 1,615 the year before. HMOs remain the dominant kind of MA–PD plan, making up 70 percent of all (unweighted) offerings in 2015. The number of PFFS plans continues to decline, from 83 in 2014 to 50 in 2015. The number of drug plans offered by local PPOs decreased by about 6 percent (27 plans), and the number of drug plans offered by regional PPOs decreased by 13 percent (4 plans) between 2014 and 2015.
- A larger share of MA–PD plans than stand-alone prescription drug plans (PDPs) offer enhanced benefits (compare Chart 10-6 with Chart 10-5). In 2015, 55 percent of all PDPs have enhanced benefits compared with 81 percent of MA–PD plans. In 2015, enhanced MA–PD plans attracted 72 percent of total MA–PD enrollment.
- Sixty-three percent of MA–PD plans have no deductible in 2015. These plans attracted 57 percent of total MA–PD enrollees in 2015.
- MA–PD plans are somewhat less likely than PDPs to provide some additional benefits in the coverage gap. In 2015, about 44 percent of MA–PD plans include some gap coverage—a decline from 50 percent the year before. Those plans account for about 45 percent of MA–PD enrollment.

Chart 10-7. Change in average Part D premiums, 2011–2015

	Average monthly premium weighted by enrollment					Cumulative change in weighted average premium, 2011–2015
	2011	2012	2013	2014	2015	
All plans						
Basic coverage	$33	$33	$32	$29	$26	–20%
Enhanced coverage	26	26	28	30	33	24
Any coverage	30	30	30	29	30	–1
PDPs						
Basic coverage	33	33	32	30	28	–14
Enhanced coverage	63	58	49	49	48	–23
Any coverage	38	38	39	38	37	–3
MA–PDs, including SNPs*						
Basic coverage	27	27	29	25	21	–23
Enhanced coverage	12	12	13	13	16	39
Any coverage	14	14	15	16	18	31
Base beneficiary premium	32.34	31.08	31.17	32.42	33.13	2

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), SNPs (special needs plans). All calculations exclude employer-only groups and plans offered in U.S. territories. In addition, MA–PD plans exclude Part B–only plans, demonstrations, special needs plans, and 1876 cost plans.
*Reflects the portion of Medicare Advantage plans' total monthly premium attributable to Part D benefits for plans that offer Part D coverage. MA–PD premiums reflect rebate dollars that were used to offset Part D premium costs. The fact that average premiums for enhanced MA–PD plans are lower than for basic MA–PD plans could reflect several factors such as different plan sponsors, different counties of operation, and differences in the average health status of plan enrollees.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

- Between 2011 and 2015, the overall average premium paid by Part D enrollees has remained very stable at about $30 per month. However, year-to-year changes have differed by the type of benefit (basic vs. enhanced coverage) and type of plan (PDP vs. MA−PD), and they generally have not corresponded to changes observed in the base beneficiary premium.

- Over the five-year period, the average enrollee premium for basic coverage in PDPs ranged from $28 to $33 and decreased by a cumulative 14 percent. The average enrollee premium for PDPs offering enhanced coverage has decreased from $63 in 2011 to $48 in 2015, a cumulative 23 percent.

- Between 2011 and 2015, the average premium paid by beneficiaries enrolled in MA−PD plans with basic coverage ranged between $21 and $29 and decreased by a cumulative 23 percent. The average premium paid by beneficiaries enrolled in MA−PD plans offering enhanced coverage has increased from $12 to $16, a cumulative 39 percent.

Chart 10-8. More premium-free (for LIS enrollees) PDPs in 2015, but some are unavailable to new enrollees

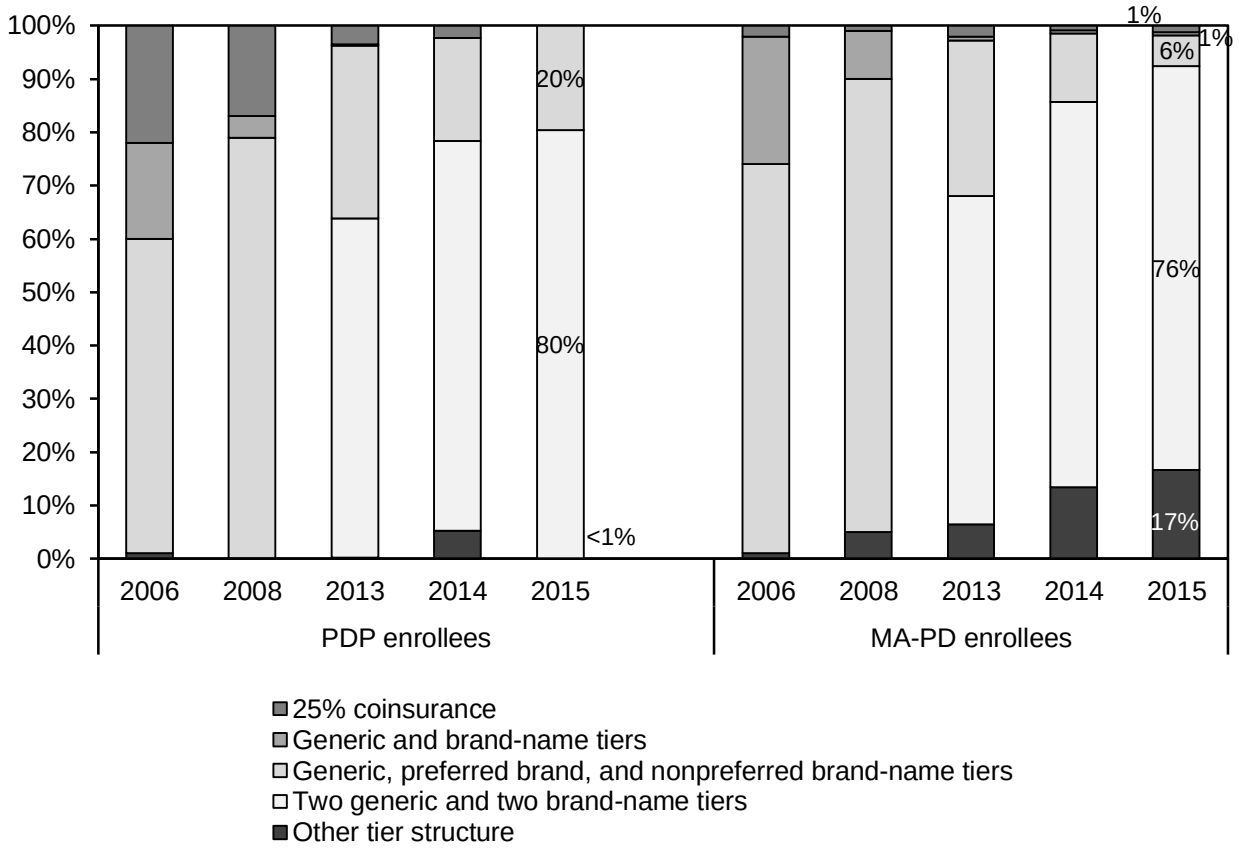
		Number of PDPs			Number of PDPs that have zero premium for LIS enrollees		
PDP region	State(s)	2014*	2015	Difference	2014*	2015	Difference
1	ME, NH	32	28	–4	7	9	2
2	CT, MA, RI, VT	33	27	–6	8	5	–3
3	NY	31	25	–6	8	8	0
4	NJ	34	29	–5	12	10	–2
5	DC, DE, MD	36	27	–9	13	10	–3
6	PA, WV	39	29	–10	13	9	–4
7	VA	35	31	–4	13	9	–4
8	NC	34	29	–5	10	8	–2
9	SC	35	31	–4	8	7	–1
10	GA	34	30	–4	9	8	–1
11	FL	35	27	–8	5	4	–1
12	AL, TN	35	30	–5	11	12	1
13	MI	36	31	–5	13	10	–3
14	OH	37	31	–6	12	8	–4
15	IN, KY	35	31	–4	15	10	–5
16	WI	33	29	–4	12	8	–4
17	IL	38	33	–5	14	10	–4
18	MO	35	31	–4	8	6	–2
19	AR	34	29	–5	12	6	–6
20	MS	33	28	–5	13	9	–4
21	LA	33	28	–5	14	11	–3
22	TX	36	32	–4	11	10	–1
23	OK	36	31	–5	12	10	–2
24	KS	33	29	–4	13	7	–6
25	IA, MN, MT, ND, NE, SD, WY	34	30	–4	10	5	–5
26	NM	36	31	–5	7	7	0
27	CO	34	30	–4	5	7	2
28	AZ	34	30	–4	11	12	1
29	NV	34	32	–2	4	4	0
30	OR, WA	35	30	–5	12	10	–2
31	ID, UT	37	31	–6	13	12	–1
32	CA	36	32	–4	9	6	–3
33	HI	29	25	–4	4	9	5
34	AK	28	24	–4	11	7	–4
	Total	1,169	1,001	–168	352	283	–69

Note: LIS (low-income subsidy), PDP (prescription drug plan).
*Includes 27 plans in 2014 and 2015 that did/may not accept new enrollees because of CMS sanctions.

Source: MedPAC based on 2014 and 2015 PDP landscape file provided by CMS.

- The total number of stand-alone PDPs decreased by 14 percent, from 1,169 in 2014 to 1,001 in 2015. The median number of plans offered in PDP regions decreased to 30 plans from 35 in 2014 (not shown in chart). AK had the fewest stand-alone PDPs, with 24; IL had the most, with 33.
- In 2015, 283 PDPs qualified to be premium free to LIS enrollees, with at least 4 PDPs available in any given region. However, 27 plans were not accepting new enrollees because of CMS sanctions, reducing the number of premium-free options available to 256 plans.

Chart 10-9. In 2015, most Part D enrollees are in plans that use a five-tier formulary structure



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Calculations are weighted by enrollment. All calculations exclude employer-only groups and plans offered in U.S. territories. In addition, MA–PD plans exclude demonstration programs, special needs plans, and 1876 cost plans. Components may not sum to totals due to rounding. Over 95 percent of PDPs and MA−PDs have a specialty tier in addition to the tiers listed above.

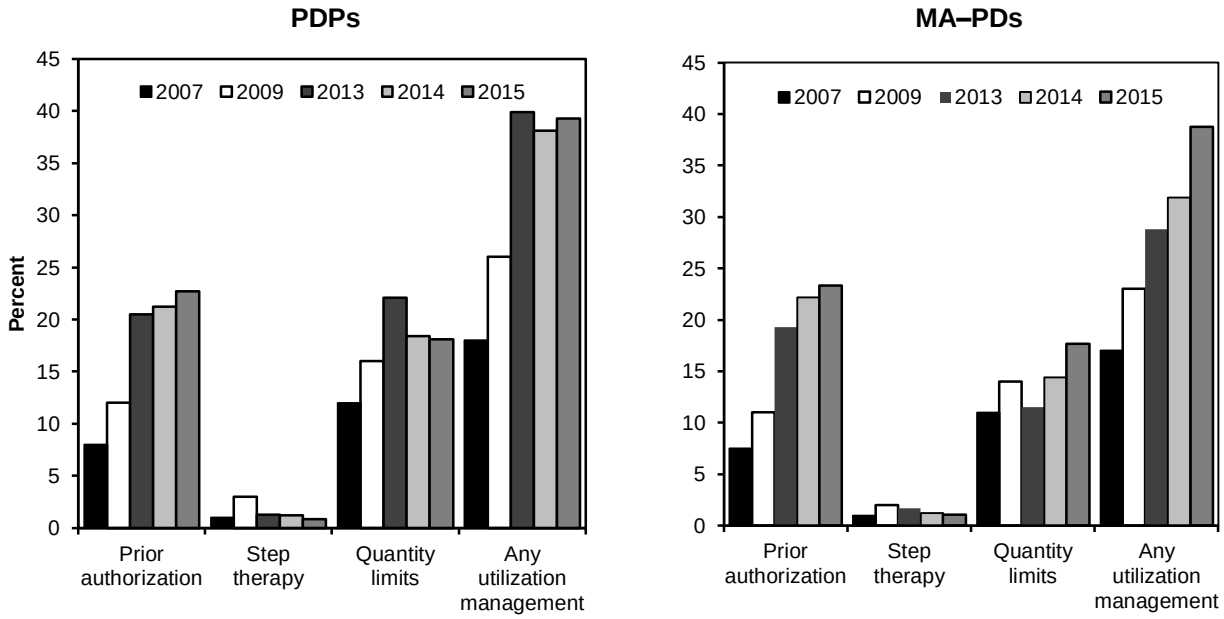
Source: MedPAC-sponsored analysis by NORC/Georgetown University/Social and Scientific Systems analysis of formularies submitted to CMS.

- Most Part D enrollees continue to choose plans that distinguish between preferred and nonpreferred brand-name drugs, with an increasing number choosing a formulary that also distinguishes between preferred and nonpreferred generic drugs. In 2015, 80 percent of PDP enrollees are in plans that have two generic and two brand-name tiers, an increase from 73 percent in 2014. About 76 percent of MA–PD enrollees are in such plans in 2015, up from 72 percent in 2014.

- For enrollees in PDPs with two generic and two brand-name tiers, the median copay in 2015 is $38 for a preferred brand and $80 for a nonpreferred brand. The median copay for generic drugs is $1 for preferred-tier drugs and $4 for nonpreferred-tier drugs. For MA–PD enrollees, in 2015, the median copay is $45 for a preferred brand, $95 for a nonpreferred brand, and $3 and $10 for a generic drug on preferred and nonpreferred tiers, respectively. In 2015, some plans are offering a “value” tier with low or no copays.

- Most plans also use a specialty tier for drugs that have a negotiated price of $600 per month or more. In 2015, median cost sharing for a specialty tier drug is 29 percent among PDPs and 33 percent among MA–PD plans.

Chart 10-10. In 2015, use of prior authorization continues to increase for both PDPs and MA–PDs



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Calculations are weighted by enrollment. All calculations exclude employer-only groups and plans offered in U.S. territories. In addition, MA–PD plans exclude demonstration programs, special needs plans, and 1876 cost plans. Values reflect the share of listed chemical entities that are subject to utilization management, weighted by plan enrollment. "Prior authorization" means that the enrollee must get preapproval from the plan before coverage. "Step therapy" refers to a requirement that the enrollee try specified drugs before being prescribed other drugs in the same therapeutic category. "Quantity limits" means that plans limit the number of doses of a drug available to the enrollee in a given time period.

Source: MedPAC-sponsored analysis by NORC/Georgetown University/Social and Scientific Systems of formularies submitted to CMS.

- The number of drugs listed on a plan's formulary does not necessarily represent beneficiary access to medications. Plans' processes for nonformulary exceptions, prior authorization (preapproval from plans before coverage), quantity limits (plan limitations on the number of doses of a particular drug covered in a given period), and step therapy requirements (enrollees must try specified drugs before being prescribed other drugs in the same therapeutic category) can affect access to certain drugs.

- In 2015, the average enrollee in a stand-alone PDP faces some form of utilization management for about 39 percent of drugs listed on a plan's formulary, a slight increase from 38 percent in 2014. Likewise, the average MA–PD enrollee faces some form of utilization management for 39 percent of drugs listed on a plan's formulary, a sizable increase from 32 percent in 2014. Part D plans typically use quantity limits or prior authorization to manage enrollees' prescription drug use.

- In 2015, the share of drugs listed on plan formularies that require quantity limits remained the same as in 2014, at 18 percent among stand-alone PDPs. Among MA–PDs, the use of quantity limits increased from about 14 percent of listed drugs to 18 percent. The share of drugs listed on plan formularies that require the use of step therapy remained very low for both stand-alone PDPs and MA–PDs.

Chart 10-11. Characteristics of Part D enrollees, 2013

	All Medicare	Part D	Plan type		Subsidy status	
			PDP	MA–PD	LIS	Non-LIS
Beneficiaries[a] (in millions)	55.1	37.8	24.2	13.7	12.4	25.4
Percent of all Medicare	100%	69%	44%	25%	22%	46%
Gender						
Male	45%	42%	42%	43%	40%	44%
Female	55	58	58	57	60	56
Race/ethnicity						
White, non-Hispanic	76	74	77	69	56	83
African American, non-Hispanic	10	11	11	11	20	7
Hispanic	9	10	7	14	16	7
Asian	3	3	3	3	5	2
Other	2	2	2	2	2	2
Age (years)[b]						
<65	19	20	22	16	42	9
65–69	26	23	22	26	15	27
70–74	19	20	19	22	12	23
75–79	14	14	14	15	10	16
80+	22	23	23	21	19	24
Urbanicity[c]						
Metropolitan	81	82	78	89	80	83
Micropolitan	10	10	12	7	11	10
Rural	8	8	10	4	9	7

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). Percentages may not sum to 100 due to rounding.
[a] Figures for Medicare and Part D include all beneficiaries with at least one month of enrollment in the respective program. A beneficiary is classified as LIS if that individual received Part D's LIS at some point during the year. For individuals who switch plan types during the year, classification into plan types is based on the greater number of months of enrollment.
[b] Age as of July 2013.
[c] Urbanicity is based on the Office of Management and Budget's core-based statistical areas as of February 2013. A metropolitan area contains a core urban area of 50,000 or more people, and a micropolitan area contains an urban core of at least 10,000 (but fewer than 50,000) people. About 1 percent of Medicare beneficiaries were excluded because of an unidentifiable core-based statistical area designation.

Source: MedPAC analysis of Medicare Part D denominator and Risk Adjustment System files from CMS.

- In 2013, 37.8 million Medicare beneficiaries (69 percent) enrolled in Part D at some point in the year. Most of them (24.2 million) were in stand-alone PDPs, with 13.7 million in MA–PD plans. Over 12 million enrollees received Part D's LIS.
- Compared with the overall Medicare population, Part D enrollees are more likely to be female and non-White. MA–PD enrollees are less likely to be disabled beneficiaries under age 65 and more likely to be Hispanic compared with PDP enrollees; LIS enrollees are more likely to be female, non-White, and disabled beneficiaries under age 65 compared with non-LIS enrollees.
- Patterns of enrollment by urbanicity for Part D enrollees were similar to the overall Medicare population, with 82 percent in metropolitan areas, 10 percent in micropolitan areas, and the remaining 8 percent in rural areas.

Chart 10-12. Part D enrollment trends, 2007–2013

	2007	2010	2013	Average annual growth rate 2007–2010	2010–2013	2007–2013
Part D enrollment (in millions)*						
Total	26.1	29.7	37.8	4.4%	8.4%	6.4%
By plan type						
PDP	18.3	18.9	24.2	1.1	8.5	4.7
MA–PD	7.8	10.6	13.7	10.9	8.8	9.9
By subsidy status						
LIS	10.4	11.3	12.4	2.7	3.1	2.9
Non-LIS	15.7	18.4	25.4	5.5	11.4	8.4
By race/ethnicity						
White, non-Hispanic	19.4	22.0	28.1	4.3	8.5	6.4
African American, non-Hispanic	2.9	3.3	4.2	4.1	8.0	6.0
Hispanic	2.5	3.0	3.6	5.8	7.0	6.4
Other	1.3	1.4	1.9	3.9	10.6	7.2
By age (years)**						
<65	5.5	6.3	7.5	4.7	6.2	5.5
65–69	5.4	6.6	8.8	6.5	10.5	8.5
70–79	8.8	9.9	13.0	3.8	9.5	6.6
80+	6.4	7.1	8.5	3.2	6.5	4.8
Part D enrollment (in percent)						
Total	100%	100%	100%			
By plan type						
PDP	70	64	64			
MA–PD	30	36	36			
By subsidy status						
LIS	40	38	33			
Non-LIS	60	62	67			
By race/ethnicity						
White, non-Hispanic	74	74	74			
African American, non-Hispanic	11	11	11			
Hispanic	10	10	10			
Other	5	5	5			
By age (years)**						
<65	21	21	20			
65–69	21	22	23			
70–79	34	33	34			
80+	25	24	23			

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income [drug] subsidy). A beneficiary is classified as LIS if that individual received Part D's LIS at some point during the year. If a beneficiary was enrolled in both a PDP and an MA–PD plan during the year, that individual was classified into the type of plan with the greater number of months of enrollment. Numbers may not sum to totals due to rounding.
*Figures include all beneficiaries with at least one month of enrollment.
**Age as of July of the respective year.

Source: MedPAC analysis of Medicare Part D denominator file from CMS.

(Chart continued next page)

Chart 10-12. Part D enrollment trends, 2007–2013 (continued)

- Part D enrollment grew faster between 2010 and 2013 (average annual growth rate (AAGR) of 8.4 percent) than between 2007 and 2010 (AAGR of 4.4 percent). Between 2010 and 2013, the largest growth in enrollment was observed for beneficiaries ages 65 to 69 (10.5 percent annually, on average), followed by beneficiaries ages 70 to 79 (9.5 percent annually, on average).

- While MA–PD plan enrollment grew faster between 2007 and 2010 (nearly 11 percent annually compared with about 1 percent annually, on average, for PDP plan enrollment), the growth rates were comparable between MA–PDs and PDPs between 2010 and 2013 (AAGR of 8.5 percent and 8.8 percent, respectively).

- The number of enrollees receiving the LIS grew modestly between 2007 and 2010 at 2.7 percent per year. Higher growth rates (3.1 percent) were observed between 2010 and 2013. The growth in the number of non-LIS enrollees declined between 2007 and 2010, but increased between 2010 and 2013. Faster enrollment growth among non-LIS enrollees is partly attributable to the recent growth in employer group waiver plans that shifted beneficiaries into Part D plans from employer plans that had previously received Medicare's retiree drug subsidy (RDS) (see Chart 10-3 for information on the RDS).

Chart 10-13. Part D enrollment by region, 2013

PDP region	State(s)	Percent of Medicare enrollment		Percent of Part D enrollment			
				Plan type		Subsidy status	
		Part D	RDS	PDP	MA–PD	LIS	Non-LIS
1	ME, NH	63%	7%	82%	18%	42%	58%
2	CT, MA, RI, VT	67	11	71	29	39	61
3	NY	74	7	57	43	38	62
4	NJ	69	7	80	20	27	73
5	DE, DC, MD	55	10	86	14	36	64
6	PA, WV	72	6	57	43	30	70
7	VA	59	5	77	23	32	68
8	NC	71	5	74	26	34	66
9	SC	61	11	69	31	38	62
10	GA	68	5	63	37	38	62
11	FL	71	6	51	49	32	68
12	AL, TN	71	4	64	36	39	61
13	MI	74	7	78	22	27	73
14	OH	75	5	67	33	27	73
15	IN, KY	71	5	75	25	33	67
16	WI	67	6	62	38	27	73
17	IL	63	13	86	14	34	66
18	MO	70	5	67	33	30	70
19	AR	66	5	75	25	41	59
20	MS	69	2	83	17	49	51
21	LA	70	6	64	36	42	58
22	TX	67	6	68	32	38	62
23	OK	65	3	78	22	34	66
24	KS	68	3	83	17	26	74
25	IA, MN, MT, NE, ND, SD, WY	70	4	74	26	25	75
26	NM	67	4	58	42	36	64
27	CO	64	9	50	50	27	73
28	AZ	68	6	48	52	28	72
29	NV	64	6	52	48	26	74
30	OR, WA	64	7	54	46	29	71
31	ID, UT	63	6	54	46	25	75
32	CA	75	5	51	49	36	64
33	HI	70	2	37	63	27	73
34	AK	41	24	98	2	57	43
	Mean	69	6	64	36	33	67
	Minimum	41	2	37	2	25	43
	Maximum	75	24	98	63	57	75

Note: PDP (prescription drug plan), RDS (retiree drug subsidy), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). Definition of regions is based on PDP regions used in Part D.

Source: MedPAC analysis of Part D enrollment data from CMS.

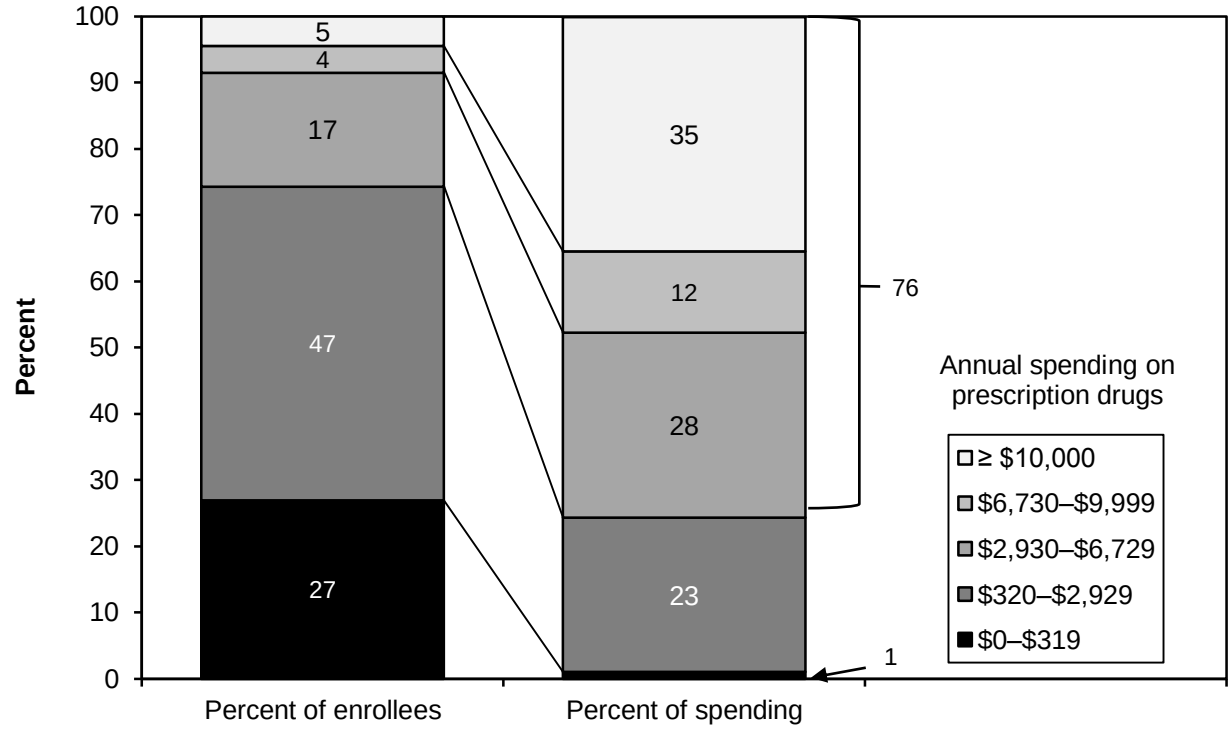
- Among Part D regions, in 2013, all but three regions (Region 5 (DE, DC, MD), Region 7 (VA), and Region 34 (AK)) had over 60 percent of all Medicare beneficiaries enrolled in Part D. Beneficiaries were less likely to enroll in Part D in regions where employer-sponsored drug coverage continues to be available. For example, in Region 34, the share of Medicare beneficiaries enrolled in Part D was 41 percent, while the share of beneficiaries enrolled in employer-sponsored plans that received the RDS was 24 percent. In other regions (Region 5 and Region 7), many beneficiaries likely received their drug coverage through the Federal Employees Health Benefits Program, which does not receive the RDS.

(Chart continued next page)

Chart 10-13. Part D enrollment by region, 2013 (continued)

- In 2013, all regions, with the exception of Region 34, experienced a decrease in the number of beneficiaries who received the RDS. The shift was likely motivated by changes made by Patient Protection and Affordable Care Act of 2010 that increased the generosity of Part D coverage and altered the tax treatment of drug expenses covered by the RDS.
- Wide variation was seen in the shares of Part D enrollees who enrolled in PDPs and MA–PD plans across PDP regions. The pattern of MA–PD enrollment is generally consistent with enrollment in Medicare Advantage plans.
- The share of Part D enrollees receiving the LIS ranged from 25 percent in Region 25 (IA, MN, MT, NE, ND, SD, and WY) and in Region 31 (ID and UT) to 57 percent in Region 34 (AK). In 20 of the 34 PDP regions, LIS enrollees accounted for 30 percent to 50 percent of enrollment. In one region (Region 34 (AK)), LIS enrollees accounted for more than half of Part D enrollment.

Chart 10-14. The majority of Part D spending is incurred by only one-quarter of all Part D enrollees, 2012



Note: "Spending" (gross) reflects payments from all payers, including beneficiaries (cost sharing), but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Annual spending cuts used for this analysis generally correspond to the parameters of the defined standard benefit. In 2012, an individual not receiving Part D's low-income subsidy and without other sources of supplemental coverage would have reached the catastrophic phase of the benefit at $6,730.39 in total drug spending, assuming that expenses for brand-name drugs accounted for 86.3 percent of total drug spending in the coverage gap. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Part D prescription drug event data from CMS.

- Medicare Part D spending is concentrated in a subset of beneficiaries. In 2012, 26 percent of Part D enrollees had annual spending of $2,930 or more, at which point enrollees were responsible for a higher proportion of the cost of the drug until their spending reached $6,730.39 under the defined standard benefit. These beneficiaries accounted for 76 percent of total Part D spending.

- The costliest 9 percent of beneficiaries, those with drug spending above the catastrophic threshold under the defined standard benefit, accounted for 47 percent of total Part D spending. Over 70 percent of beneficiaries with the highest spending received Part D's low-income subsidy (see Chart 10-15). Spending on prescription drugs is less concentrated than Medicare Part A and Part B spending. In 2010, the costliest 5 percent of beneficiaries accounted for 39 percent of annual Medicare fee-for-service (FFS) spending, and the costliest quartile accounted for 82 percent of Medicare FFS spending.

- In 2012, the share of spending accounted for by the costliest 5 percent of beneficiaries increased to 35 percent from 33 percent in 2011.

Chart 10-15. Characteristics of Part D enrollees, by spending levels, 2012

	Annual drug spending		
	<$2,930	$2,930–$6,729	≥$6,730
Sex			
Male	43%	39%	41%
Female	57	61	59
Race/ethnicity			
White, non-Hispanic	74	75	70
African American, non-Hispanic	11	11	14
Hispanic	10	10	10
Other	5	5	6
Age (years)			
<65	18	21	43
65–69	25	19	16
70–74	20	19	14
75–80	14	15	11
80+	23	26	17
LIS status*			
LIS	30	45	72
Non-LIS	70	55	28
Plan type**			
PDP	60	69	78
MA–PD	40	31	22

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). "Spending" (gross) reflects payments from all payers, including beneficiaries (cost sharing), but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. A small number of beneficiaries were excluded from the analysis because of missing data. Percentages may not sum to 100 due to rounding.
*A beneficiary was assigned LIS status if that individual received Part D's LIS at some point during the year.
**If a beneficiary was enrolled in both a PDP and an MA–PD plan during the year, that individual was classified in the type of plan with the greater number of months of enrollment.

Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

- In 2012, Part D enrollees with annual drug spending between $2,930 and $6,729 and those with spending at or above $6,730 were more likely to be female than enrollees with annual spending below $2,930 (61 percent and 59 percent, respectively, compared with 57 percent).
- Part D enrollees with annual spending at or above $6,730 were more likely to be non-White, disabled enrollees under age 65 receiving the LIS compared with those with annual spending below $2,930.
- Most Part D enrollees with spending at or above $6,730 were enrolled in stand-alone PDPs (78 percent) compared with MA–PD plans (22 percent). In contrast, beneficiaries with annual spending below $2,930 were more likely to be in MA–PDs compared with those with higher annual spending (40 percent compared with 22 percent). This finding reflects the fact that most LIS enrollees are more costly on average and are in PDPs.

Chart 10-16. Part D spending and use per enrollee, 2012

		Plan type		LIS status	
	Part D	PDP	MA–PD	LIS	Non-LIS
Total gross spending (billions) [a]	$89.8	$64.4	$25.4	$48.4	$41.4
Total number of prescriptions[b] (millions)	1,640	1,073	567	691	949
Average spending per prescription	$55	$60	$45	$70	$44
Per enrollee per month					
Total spending[a]	$235	$270	$178	$362	$167
Out-of-pocket spending[c]	33	34	31	7	47
Plan liability[d]	143	160	115	213	106
Low-income cost-sharing subsidy	50	65	25	143	N/A
Number of prescriptions[b]	4.3	4.5	4.0	5.2	3.8

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy), N/A (not applicable). "Gross spending" reflects payments from all payers, including beneficiaries (cost sharing), but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Part D prescription drug event (PDE) records are classified into plan types based on the contract identification on each record. For purposes of classifying the PDE records by LIS status, monthly LIS eligibility information in Part D's denominator file was used. Estimates are sensitive to the method used to classify PDE records to each plan type and LIS status. Numbers may not sum to totals due to rounding.
[a] "Total gross spending" includes slightly over $2.7 million in manufacturer discounts for brand-name drugs filled by non-LIS enrollees during the coverage gap.
[b] Number of prescriptions is standardized to a 30-day supply.
[c] "Out-of-pocket (OOP) spending" includes all payments that count toward the annual OOP spending threshold.
[d] "Plan liability" includes plan payments for drugs covered by both basic and supplemental (enhanced) benefits.

Source: MedPAC analysis of Medicare Part D PDE data and denominator file from CMS.

- In 2012, gross spending on drugs for the Part D program totaled $89.8 billion, with about 72 percent ($64.4 billion) accounted for by Medicare beneficiaries enrolled in PDPs. Part D enrollees receiving the LIS accounted for about 54 percent ($48.4 billion) of the total. Manufacturer discounts for brand-name drugs filled by non-LIS enrollees while they were in the coverage gap accounted for about 3 percent of the total (or about 6 percent of the gross spending by non-LIS enrollees).

- The number of prescriptions filled by Part D enrollees totaled 1.64 billion, with about two-thirds (1,073 million) accounted for by PDP enrollees. The 36 percent of enrollees who received the LIS accounted for about 42 percent (691 million) of the total number of prescriptions filled.

- Part D enrollees filled 4.3 prescriptions at $235 per month on average, a decrease from $239 per month in 2011 for roughly the same number of prescriptions filled, on average. PDP enrollees had higher average monthly spending and more prescriptions filled compared with MA–PD plan enrollees. The average monthly plan liability for MA–PD enrollees ($115) was considerably lower than that of PDP enrollees ($160), while average monthly OOP spending was similar for enrollees in both types of plans ($31 vs. $34, respectively). The average monthly low-income cost-sharing subsidy was much lower for MA–PD enrollees ($25) compared with PDP enrollees ($65).

- Average monthly spending per enrollee for an LIS enrollee ($362) was more than double that of a non-LIS enrollee ($167), while the average number of prescriptions filled per month by an LIS enrollee was 5.2 compared with 3.8 for a non-LIS enrollee. LIS enrollees had much lower OOP spending, on average, than non-LIS enrollees ($7 vs. $47). Part D's LIS pays for most of the cost sharing for LIS enrollees, averaging $143 per month in 2012.

Chart 10-17. Trends in Part D spending and use per enrollee, 2007–2012

	Average spending / use						Average annual growth rate, 2007–2012	
	2007	2008	2009	2010	2011	2012	Number	Percent
Average spending								
All Part D	$212	221	228	231	239	235	$5	2.1%
By LIS status								
LIS	$301	324	339	348	364	362	$12	3.8
Non-LIS	$156	159	163	163	167	167	$2	1.4
By plan type								
PDP	$239	250	260	265	274	270	$6	2.5
MA−PD	$151	162	169	172	178	178	$5	3.3
Average number of prescriptions*								
All Part D	3.9	4.1	4.1	4.2	4.3	4.3	0.1	1.9%
By LIS status								
LIS	4.6	4.9	5.0	5.1	5.1	5.2	0.1	2.4
Non-LIS	3.4	3.6	3.6	3.7	3.8	3.8	0.1	2.4
By plan type								
PDP	4.1	4.3	4.4	4.4	4.5	4.5	0.1	1.7
MA−PD	3.4	3.6	3.7	3.8	3.9	4.0	0.1	2.9

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). "Spending" (gross) reflects payments from all payers, including beneficiaries (cost sharing), but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Part D prescription drug event (PDE) records are classified into plan types based on the contract identification on each record. For purposes of classifying the PDE records by LIS status, monthly LIS eligibility information in Part D's denominator file was used. Estimates are sensitive to the method used to classify PDE records to each plan type and LIS status. Numbers may not sum to totals due to rounding.
* Number of prescriptions is standardized to a 30-day supply.

Source: MedPAC analysis of Medicare Part D PDE data and denominator file from CMS.

- Between 2007 and 2012, the average per capita spending for Part D–covered drugs grew at an average annual rate of 2.1 percent, or by about 11 percent cumulatively. Growth in average per capita spending has fluctuated over the years, ranging from a negative 1.5 percent growth between 2011 and 2012, to a growth of over 4 percent during the first few years of the program.

- Spending for non-LIS enrollees remained relatively flat compared with LIS enrollees (average annual growth rate of 1.4 percent compared with 3.8 percent) during the 2007 to 2012 period, resulting in a larger difference in per capita spending between the two groups—from $145 in 2007 to nearly $200 per member per month in 2012. The growth in the number of prescriptions filled by LIS and non-LIS enrollees was comparable during this period.

- The growth in per capita drug spending among MA−PD enrollees exceeded that of PDP enrollees during the 2007 to 2012 period (3.3 percent compared with 2.5 percent), but the average growth was lower for MA−PD enrollees in terms of the dollar increase ($5 compared with $6), and the average per capita spending for MA−PD enrollees continued to be below that of PDP enrollees by about $90.

Chart 10-18. Top 15 therapeutic classes of drugs covered under Part D, by spending and volume, 2012

Top 15 therapeutic classes by spending	Dollars		Top 15 therapeutic classes by volume	Prescriptions	
	Billions	Percent		Millions	Percent
Diabetic therapy	$8.7	9.7%	Antihypertensive therapy agents	171.4	10.5%
Antihyperlipidemics	7.5	8.4	Antihyperlipidemics	163.8	10.0
Asthma/COPD therapy agents	6.8	7.5	Beta adrenergic blockers	104.4	6.4
Antipsychotics	6.3	7.0	Diabetic therapy	102.6	6.3
Antihypertensive therapy agents	5.3	5.9	Antidepressants	93.1	5.7
Antivirals	4.0	4.4	Diuretics	85.8	5.2
Peptic ulcer therapy	3.7	4.1	Peptic ulcer therapy	83.9	5.1
Antidepressants	3.4	3.8	Analgesics (narcotic)	76.1	4.6
Analgesics (narcotic)	3.2	3.5	Calcium channel blockers	71.4	4.4
Platelet aggregation inhibitors	2.6	2.9	Thyroid therapy	60.2	3.7
Analgesic (anti-inflammatory/ antipyretic, non-narcotic)	2.6	2.9	Anticonvulsant	48.2	2.9
Anticonvulsant	2.5	2.8	Antibacterial agents	45.0	2.7
Cognitive disorder therapy (antidementia)	2.2	2.5	Asthma/COPD therapy agents	44.6	2.7
Calcium and bone metabolism regulators	1.7	1.9	Analgesic (anti-inflammatory/ antipyretic, non-narcotic)	30.8	1.9
Antineoplastic enzyme inhibitors	1.7	1.9	Anticoagulants	27.1	1.6
Subtotal, top 15 classes	62.2	69.2	Subtotal, top 15 classes	1,208.3	73.7
Total, all classes	89.8	100.0	Total, all classes	1,639.9	100.0

Note: COPD (chronic obstructive pulmonary disease). "Spending" (gross) reflects payments from all payers, including beneficiaries (cost sharing), but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. "Volume" is the number of prescriptions, standardized to a 30-day supply. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System 1.0. Numbers may not sum to totals due to rounding.

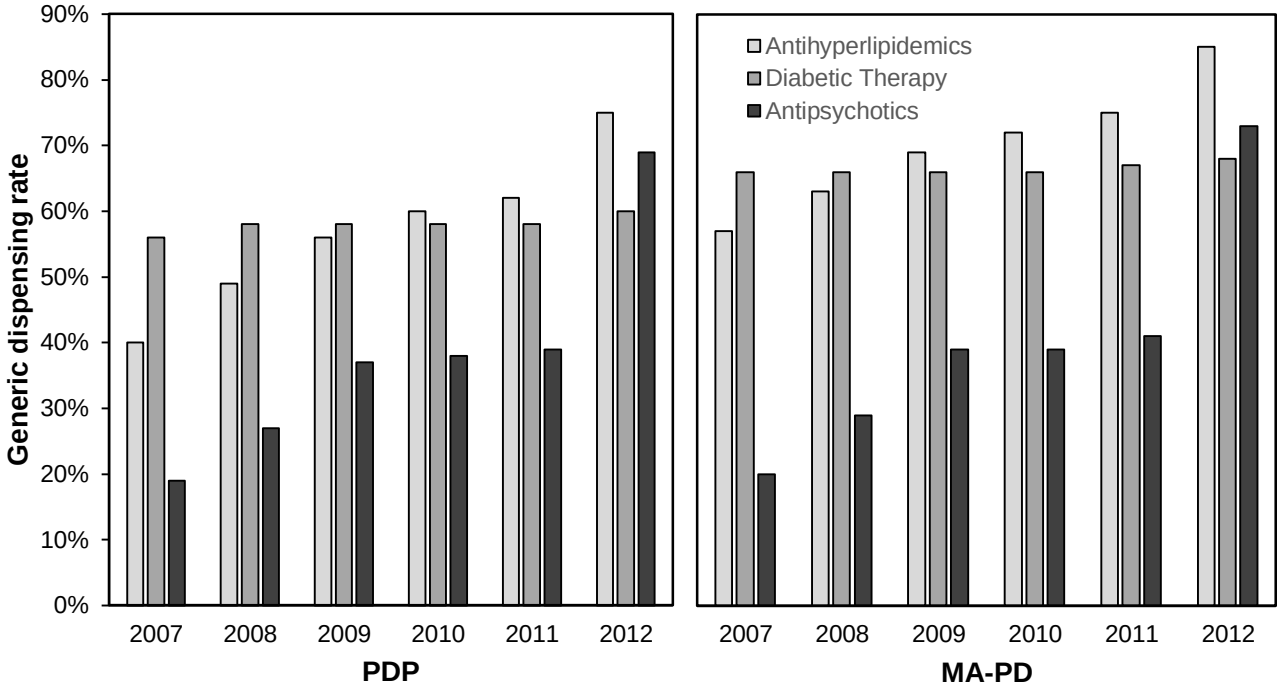
Source: MedPAC analysis of Medicare Part D prescription drug event data from CMS.

- The list of the top 15 therapeutic classes has been stable since 2007, with the majority of therapeutic classes appearing on the list in every year. In 2012, spending on prescription drugs covered by Part D plans totaled $89.8 billion. The top 15 therapeutic classes by spending accounted for about 69 percent of the total. Over 1.6 billion prescriptions were dispensed in 2012, with the top 15 therapeutic classes by volume accounting for nearly 74 percent of the total.

- In 2012, spending on drugs to treat diabetes totaled $8.7 billion, exceeding spending on drugs to treat high cholesterol (antihyperlipidemics) and psychiatric conditions (antipsychotics) for the first time since 2007. Spending on antipsychotics declined by $1.3 billion between 2011 and 2012.

- Nine therapeutic classes are among the top 15, based on both spending and volume. Central nervous system agents (antipsychotics, anticonvulsants, and antidepressants) and cardiovascular agents (antihyperlipidemics and antihypertensive therapy agents) dominate the list by spending, each accounting for about one-fifth of spending, while cardiovascular agents (antihyperlipidemics, antihypertensive therapy agents, beta-adrenergic blockers, calcium channel blockers, and diuretics) dominate the list by volume, accounting for about 50 percent of the prescriptions in the top 15 therapeutic classes.

Chart 10-19. Generic dispensing rate for selected therapeutic classes, by plan type, 2007–2012



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Prescriptions are standardized to a 30-day supply. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System 1.0. "Generic dispensing rate" is defined as the proportion of generic prescriptions dispensed within a therapeutic class. Part D prescription drug event records are classified as PDP or MA–PD records based on the contract identification on each record.

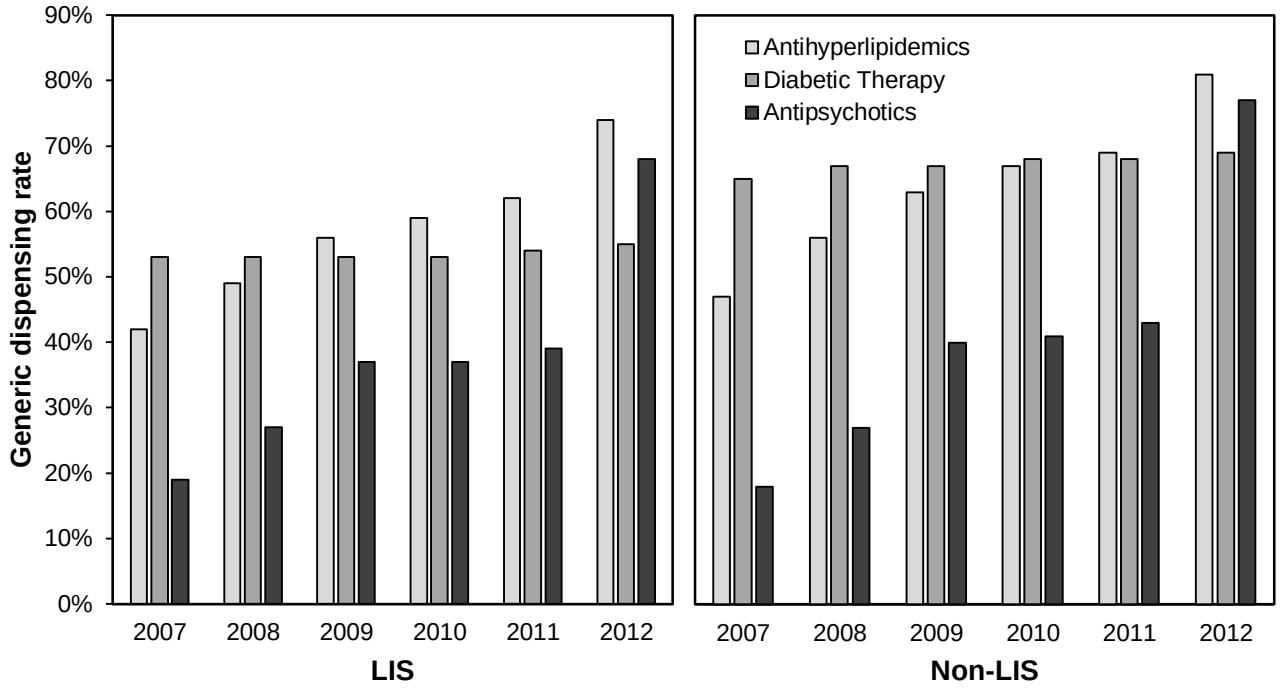
Source: MedPAC analysis of Medicare Part D prescription drug event data from CMS.

- The share of prescriptions that are for generic drugs (generic dispensing rate, or GDR) has increased steadily over the years, from 61 percent in 2007 to 81 percent in 2012 across all therapeutic classes (data not shown).

- The GDR in a given class depends, in large part, on the availability of generic drugs in the class. For example, the GDR for antipsychotics was among the lowest within the top 15 therapeutic classes until some of the key drugs came off patent and generic versions became available in 2011 and 2012. Other factors, such as prescribing behavior and patients' medication needs and/or preferences can also affect the GDR.

- Between 2007 and 2012, GDRs for PDP enrollees were generally lower than those of MA–PD enrollees for most of the top 15 therapeutic classes. For example, GDRs for diabetic therapy among the MA–PD enrollees exceeded that of PDP enrollees by between 8 percentage points and 10 percentage points during this period. The difference in GDRs for antihyperlipidemics between MA–PD enrollees and PDP enrollees decreased during this period (from 17 percentage points in 2007 to about 10 percentage points in 2012), but antihyperlipidemics are still one of the classes with the largest difference in GDRs between PDPs and MA–PDs. Some of the difference in GDRs reflects the fact that, relative to MA–PDs, PDPs have a higher proportion of LIS enrollees, who are less likely to take a generic medication in a given therapeutic class (see Chart 10-20).

Chart 10-20. Generic dispensing rate for selected therapeutic classes, by LIS status, 2012



Note: LIS (low-income subsidy). Prescriptions are standardized to a 30-day supply. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System 1.0. "Generic dispensing rate" is defined as the proportion of generic prescriptions dispensed within a therapeutic class. Part D prescription drug event (PDE) records are classified as LIS or non-LIS records based on monthly LIS eligibility information in Part D's denominator file. Estimates are sensitive to the method used to classify PDE records as LIS or non-LIS.

Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

- Between 2007 and 2012, the share of prescriptions that are for generic drugs (generic dispensing rate, or GDR) have increased for both LIS and non-LIS enrollees. However, LIS enrollees have had a consistently lower GDR than non-LIS enrollees, and the difference has grown from 2 percentage points in 2007 to 5 percentage points in 2012 (data not shown).

- The difference in GDRs for antihyperlipidemics between LIS and non-LIS enrollees remained stable at around 7 percentage points to 8 percentage points for most of the years between 2007 to 2012, which is in contrast to the large differences observed between PDP and MA−PD enrollees, which ranged from 10 percentage points to 17 percentage points during this period (see Chart 10-19). These trends suggest that the narrowing of the gap in GDRs between PDPs and MA−PDs is likely attributable to the increase in the use of generic antihyperlipidemics by non-LIS enrollees in PDPs.

- Other notable differences in GDRs between LIS and non-LIS enrollees include a large and persistent difference of around 14 percentage points to 15 percentage points for diabetic therapy and a 9 percentage point difference in GDRs observed in 2012 for antipsychotics (compared with a difference of less than 4 percentage points before 2012) after generic versions became available for some of the key drugs in the class. Multiple factors likely contribute to the difference in GDRs.

Chart 10-21. Drug spending and use, and characteristics of beneficiaries filling the most prescriptions, 2012

	Beneficiaries in the top 5 percent[a]		
		As a percent of Part D	All Part D
Number of beneficiaries (in millions)	1.6	5%	33.8
Aggregate spending and use			
Gross spending (in billions)	$17.4	19	$89.8
Number of prescriptions[b] (in millions)	229	19	1,217
Average spending per prescription	$76		$74
Per enrollee per year			
Gross spending	$10,923		$2,824
Out-of-pocket spending[c]	$490		$392
Number of prescriptions[b]	144		38
Demographic characteristics			
Percent female	66%		58%
Percent White	71		74
Percent LIS	79		36
Percent PDP	77		63

Note: LIS (low-income subsidy), PDP (prescription drug plan). "Gross spending" reflects payments from all payers, including beneficiaries (cost sharing), but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies.
[a] Top 5 percent is based on volume of prescriptions filled among those who filled at least one prescription in 2012. Because roughly 7 percent of Part D enrollees did not fill any prescriptions for a Part D–covered drug in 2012, the "top 5 percent" translates to about 4.7 percent of all Part D enrollees. The figures reported in the table include claims for slightly over 600 beneficiaries who did not have a record of Part D enrollment in the denominator file and claims that were missing beneficiary identification information. These claims accounted or over 88,000 prescriptions at a gross cost of about $6 million.
[b] "Number of prescriptions" are based on counts of prescription drug events (PDEs) (not standardized to a 30-day supply).
[c] "Out-of-pocket (OOP) spending" includes all payments that count toward the annual OOP spending threshold.

Source: MedPAC analysis of Medicare Part D PDE data and denominator file from CMS.

- In 2012, Part D enrollees in the top 5 percent (1.6 million), based on the number of prescriptions filled, accounted for $17.4 billion in gross spending (19 percent of total gross spending) for drugs covered under the Part D program. The number of prescriptions filled by enrollees in the top 5 percent totaled 229 million, or 19 percent of all prescriptions filled under the Part D program.

- In 2012, Part D enrollees in the top 5 percent each filled a total of 144 prescriptions at a gross cost of $10,923, on average, compared with an average of 38 prescriptions each at a gross cost of $2,824 for all Part D enrollees. Compared with the difference in gross spending and the number of prescriptions filled, the difference in beneficiary out-of-pocket spending between enrollees in the top 5 percent and all Part D enrollees was much smaller ($490 compared with $392).

- Compared with the overall Part D population, enrollees in the top 5 percent were more likely to be female and non-White. Nearly 80 percent of the enrollees in the top 5 percent received the low-income subsidy compared with 36 percent for all Part D enrollees, and 77 percent were enrolled in a stand-alone prescription drug plan compared with 63 percent for all Part D enrollees.

Chart 10-22. Part D spending and use, 2013

	Part D	Plan type	
		PDP	MA–PD
Total gross spending (billions)	$103.6	$72.3	$28.6
Total number of prescriptions* (millions)	1,368	900	440
Average cost per prescription	$76	$80	$65
Total gross spending by specialty			
Primary care providers**	$60.3	$41.5	$17.5
Specialty and other providers	$43.3	$30.8	$11.2
Total number of prescriptions* by specialty			
Primary care providers**	974.0	639.4	319.8
Specialty and other providers	394.2	260.7	119.8
Average cost per prescription			
Primary care providers**	$61.95	$64.96	$54.58
Specialty and other providers	$109.79	$117.97	$93.20

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). "Gross spending" reflects payments from all payers, including beneficiaries (cost sharing), but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Part D prescription drug event (PDE) records are classified into plan types based on the contract identification on each record. Numbers may not sum to totals due to rounding.
* "Number of prescriptions" is a count of prescription drug events and is not adjusted for the size (number of days' supply) of the prescriptions. As such, they are not comparable with the 2012 prescription counts shown in Chart 10-16 through Chart 10-21.
** The definition of "primary care" used here is based on that used for the Primary Care Incentive Payment Program and includes practitioners who have a primary Medicare specialty designation of family practice, internal medicine, pediatrics, geriatrics, nurse practitioner and clinical nurse specialist, or physician assistant.

Source: MedPAC analysis of Medicare Part D prescriber-level public use file from CMS.

- In 2013, gross spending on drugs for the Part D program totaled $103.6 billion, with about 70 percent ($72.3 billion) accounted for by Medicare beneficiaries enrolled in PDPs. The number of prescriptions filled by Part D enrollees totaled about 1.37 billion, with about two-thirds (900 million) accounted for by PDP enrollees. The cost per prescription dispensed averaged $76 across all Part D enrollees. The average cost per prescription is lower among MA–PD enrollees ($65) compared with that of PDP enrollees ($80).

- Prescriptions written by primary care providers accounted for about 58 percent ($60.3 billion) of the gross spending and 71 percent (974 million) of prescriptions dispensed under the Part D program. The share of spending and prescriptions written by primary care providers were higher in MA–PDs (about 61 percent of gross spending and about 73 percent of prescriptions) than in PDPs (about 57 percent of gross spending and about 71 percent of prescriptions).

- The average cost per prescription dispensed was lower among primary care providers (about $62) compared with specialty and other providers (about $110). The cost per prescription dispensed for MA–PD enrollees was lower than that of PDP enrollees regardless of the provider type (primary care vs. specialty and others).

Chart 10-23. Part D patterns of prescribing by provider type, 2013

		Provider type	
	Part D	Primary care*	Specialty/others
Number of individual prescribers (thousands)	1,043	420	623
Percent of all individual prescribers		40%	60%
Average beneficiary (patient) count	143	184	115
Average per beneficiary			
Gross spending	$592	$690	$523
Number of prescriptions**	6.7	9.8	4.5
Prescribers in the top 1 percent based on number of prescriptions filled per beneficiary			
Number of individual prescribers	9,054	7,490	1,564
Percent of all individual prescribers		83%	17%
Total gross spending (billions)	$8.0	$6.8	$1.2
Percent of total gross spending	8%	11%	3%
Total number of prescriptions** (millions)	131	115	16
Percent of total gross spending	10%	12%	4%
Average per beneficiary			
Gross spending	$3,344	$3,049	$4,753
Number of prescriptions**	44	44	45

Note: "Gross spending" reflects payments from all payers, including beneficiaries (cost sharing), but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Numbers may not sum to totals due to rounding.
* The definition of "primary care" used here is based on that used for the Primary Care Incentive Payment Program and includes practitioners who have a primary Medicare specialty designation of family practice, internal medicine, pediatrics, geriatrics, nurse practitioner and clinical nurse specialist, and physician assistant.
** "Number of prescriptions" is a count of prescription drug events and is not adjusted for the size (number of days' supply) of the prescriptions. As such, they are not comparable to the 2012 prescription counts shown in Chart 10-16 through Chart 10-21.

Source: MedPAC analysis of Medicare Part D prescriber-level public use file from CMS.

- In 2013, about 1 million individual providers wrote prescriptions for Medicare beneficiaries that were filled under Part D. Of those, about 40 percent were primary-care providers and 60 percent were specialty or other types of providers.
- The average count of (Medicare only) beneficiaries (patients) was higher among primary-care providers compared with specialty and other types of providers—184 beneficiaries versus 115.

(Chart continued next page)

Chart 10-23. Part D patterns of prescribing by provider type, 2013 (continued)

- On a per beneficiary basis, average gross spending for Part D prescriptions was higher for prescriptions written by primary-care providers ($690) compared with the average for specialty and other providers ($523). Primary-care providers also wrote more prescriptions per beneficiary, on average, than specialty and other providers: 9.8 compared with 4.5.

- More than 9,000 prescribers were among the top 1 percent of all prescribers, as ranked by the average number of Part D prescriptions filled per beneficiary in 2013. Of those prescribers, 83 percent were primary-care providers and 17 percent were specialty and other providers.

- The top 1 percent of prescribers accounted for 8 percent of total gross spending and 10 percent of all prescriptions filled. Among primary-care prescribers, results were more concentrated: the top 1 percent of prescribers accounted for 11 percent of gross spending and 12 percent of all prescriptions.

- Among the prescriptions that were written by prescribers ranked among the top 1 percent of all prescribers in 2013, per beneficiary Part D spending averaged more than $3,000 for a total of 44 to 45 prescriptions filled.

Chart 10-24. Part D patterns of prescribing for selected specialties, 2013

	Number of individual Part D prescribers (thousands)	Share of all Part D prescribers (percent)	Average per beneficiary	
			Gross spending (in dollars)	Number of prescriptions
All Part D	1,042.6	100%	$592	6.7
All specialty/others	622.6	60	523	4.5
Selected specialties:				
Cardiology	22.7	4	597	9.3
Psychiatry	25.9	4	1,417	13.4
Neurology	13.1	2	2,213	7.9
Nephrology	7.9	1	1,315	10.0
Infectious disease	4.9	1	4,515	10.1
Endocrinology	5.3	1	1,460	8.9

Note: "Gross spending" reflects payments from all payers, including beneficiaries (cost sharing), but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. "Number of prescriptions" is a count of prescription drug events and is not adjusted for the size (number of days' supply) of the prescriptions. As such, they are not comparable with the 2012 prescription counts shown in Chart 10-16 through Chart 10-21.

Source: MedPAC analysis of Medicare Part D prescriber-level public use file from CMS.

- Cardiologists and psychiatrists were among the most numerous types of specialty-care prescribers, each making up 4 percent of all individual Part D prescribers in 2013. An additional 2 percent of all Part D prescribers had a neurology specialty.
- Cardiologists wrote an average of 9.3 prescriptions per beneficiary for a combined $597 in average gross spending. That average number of prescriptions is considerably higher than the overall Part D average of 6.7 per beneficiary. However, average gross spending per beneficiary was about the same for cardiologists as for all Part D prescribers: $597 compared with $592, which reflects the widespread availability of generic cardiology medications.
- By comparison, other specialties had much higher Part D gross spending per beneficiary. Infectious disease specialists had the highest spending per beneficiary at $4,515, followed by neurologists at $2,213. Psychiatrists had the highest average number of prescriptions filled per beneficiary, at 13.4 compared with the overall average of 6.7.